STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 88034-001**
v

Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 31st day of July 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On May 20, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on May 28, 2008.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on June 9, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM Flexible Blue Individual Market (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

From September 6, 2007 through December 24, 2007, the Petitioner received various

services such as a colonoscopy, related facility fees, anesthesia and laboratory charges. The approved amounts for these services were applied to the Petitioner's deductible. The Petitioner appealed BCBSM's application of the deductible to her care. BCBSM held a managerial-level conference on April 3, 2008, and issued a final adverse determination dated April 8, 2008.

III
ISSUE

Did BCBSM correctly process the Petitioner's claims for the care she received from September 6, 2007 through December 24, 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says she made a decision to have an elective procedure (colonoscopy) in October 2007 based on information given to her by a BCBSM customer representative. She was told that if she met her deductible in the last quarter of the year that it would carry over to the next year (2008). Had she been given the correct information, she would have waited until January to have the colonoscopy and would not be responsible for an additional $1,500.00 for 2008.The Petitioner acknowledges that BCBSM's website now gives more information about this policy than it did when she applied for it.

The Petitioner indicates that she called BCBSM on August 30, 2007. She was told that a colonoscopy was not a preventative procedure and the first $1,500.00 would apply to her deductible. When she asked whether her deductible would carry over to 2008 she was told it would.

The Petitioner asks, if she can't rely on her insurance company for accurate information about her benefits who can she rely on? She had the money to cover one $1,500.00 deductible but not two. She is now being threatened with collection. The Petitioner asks that BCBSM be required to cover the $1,500.00 deductible for 2008 since it was a BCBSM employee's misinformation that put her in this situation.

BCBSM's Argument

The certificate is designed to be used with a health savings account. The deductibles required under this plan are based on the amounts the government allows for these accounts. These amounts are updated each year.

The certificate indicates on page 2.1:

> You are required to pay a deductible each calendar year for covered services provided by panel providers.
> - $1,500 for a one-person contract
> - $3,000 for a family contract (two or more persons)

BCBSM says it correctly processed the claims for the colonoscopy and other services the Petitioner received from September through December 2007. This included the $1,500 deductible provided for in the certificate for panel services.

BCBSM reviewed its records and says it can find no documentation that a representative from BCBSM told the Petitioner that there was a fourth quarter deductible carry over. The fourth quarter deductible carryover, where medical expenses from the fourth quarter of the year can be applied to the next year's deductible, is only applicable to specific groups. The Petitioner's group is not one of them. Therefore, BCBSM contends it did not misinform the Petitioner about her benefits.

BCBSM believes that it paid the proper amount under the certificate language and is not required to pay any additional amount.

Commissioner's Review

The certificate explains that the Petitioner is required to meet a $1,500.00 deductible for most covered services from providers in BCBSM's PPO panel. The Commissioner finds that BCBSM correctly processed the benefits for the Petitioner's 2007 and 2008 care according to the terms and provisions of the certificate and its riders.

The Petitioner does not really find fault with BCBSM's application of the terms of the certificate to the service in this case. Her principal complaint is that she was given misinformation by BCBSM and, by acting in reliance on that information, incurred considerable out-of-pocket costs

that she could have avoided. BCBSM disputes her contention, saying that it could find no records of telephone calls where incorrect information was conveyed. This kind of dispute cannot be resolved in a review under the Patient's Right to Independent Review Act (PRIRA).

Under PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms of the applicable insurance contract and state law. Resolution of a factual dispute like the one described by the Petitioner cannot be the basis of a PRIRA decision because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements and witness credibility.

In conclusion, the Commissioner finds that BCBSM has correctly applied the provisions of the Petitioner's certificate.

V
ORDER

BCBSM's final adverse determination of April 8, 2008, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's care in 2007 or 2008.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.